

Social Security Administration
Retirement, Survivors and Disability Insurance
Notice of Disapproved Claim

Great Lakes Program Service Center
600 West Madison Street
Chicago, Illinois 60661-2474
Date: June 27, 2014
Claim Number: ~~296 60 959 411 1~~



001697 1 MB 0.435 0009 LR M08P4 0623 01



TIJUANA L MORRIS
14841 JOY RD APT 2
DETROIT, MI 48228-2470

We are writing to tell you that you do not qualify for disability benefits.

Why We Cannot Pay You

You do not qualify for disability benefits because you have not worked long enough under Social Security.

We figure work under Social Security in credits. Please read the enclosed pamphlet, "How You Earn Social Security Credits," which explains how the credits are earned and how many a person must have to receive benefits.

Since you do not have enough work credits to qualify for benefits, we did not make a decision about whether you are disabled under our rules.

Other Social Security Benefits

You are not due any other Social Security benefits. In the future, if you think you may qualify for benefits from us, you will need to apply again.

Need Help Getting A Job?

If you want to ask about counseling, training, and other services to help you in going to work, contact the nearest State vocational rehabilitation office. Their phone number is in the blue pages of your telephone book under State Government. You can also go to our Office of Employment Support Programs' website at www.chooseworkttw.net/resource/jsp/searchByState.jsp. Click on the State where you live and it will provide your local vocational rehabilitation agency's address and telephone number.

Enclosure(s):
Pub 05-10072



Do You Disagree With The Decision?

If you do not agree with this decision, you have the right to appeal. We will review your case and look at any new facts you have. A person who did not make the first decision will decide your case. We will review the parts of the decision that you think are wrong and correct any mistakes. We may also review the parts of our decision that you think are right. We will make a decision that may or may not be in your favor.

- You have 60 days to ask for an appeal.
- The 60 days start the day after you receive this letter. We assume you received this letter 5 days after the date on it unless you show us that you did not receive it within the 5-day period.
- You must have a good reason if you wait more than 60 days to ask for an appeal.
- You can file an appeal with any Social Security office. You must ask for an appeal in writing. Please use our "Request for Reconsideration" form, SSA-561-U2. You may go to our website at www.socialsecurity.gov/online/ to find the form. You can also call, write, or visit us to request the form. If you need help to fill out the form, we can help you by phone or in person.

New Application

You have the right to file a new application at any time, but filing a new application is not the same thing as appealing this decision. If you disagree with this decision and you file a new application instead of appealing:

- you might lose some benefits, or not qualify for any benefits, and
- we could deny the new application using this decision, if the facts and issues are the same.

So, if you disagree with this decision, you should file an appeal within 60 days.

If You Want Help With Your Appeal

You can have a friend, representative, or someone else help you. There are groups that can help you find a representative or give you free legal services if you qualify. There are also representatives who do not charge unless you win your appeal. Your local Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it. And if you hire a representative who is eligible for direct pay, we will withhold up to 25 percent of any past due benefits to pay toward the fee.



If You Have Any Questions

We invite you to visit our website at www.socialsecurity.gov on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local Social Security office at 1-888-366-6152. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY
26840 W SEVEN MILE RD
REDFORD MI 48240

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

Social Security Administration



You recently contacted us about filing for disability benefits. Did you know that you can now apply for Social Security disability benefits online through the Social Security internet site? This letter explains how to file your application for disability benefits through the Social Security website.

WHY SHOULD YOU COMPLETE YOUR APPLICATION ON THE SOCIAL SECURITY WEBSITE?

- You can save time by applying from home or another convenient location. You do not have to travel to your local Social Security office.
- You can submit your claim immediately, without waiting for an appointment with your local Social Security office.
- Social Security ensures the confidentiality of your information by using the strongest security techniques commercially available.

HOW DO YOU COMPLETE A DISABILITY APPLICATION ON THE SOCIAL SECURITY WEBSITE?

Applying for disability benefits online is a simple process. Take the following steps to complete and submit your application.

- Using any internet browser software, go to **www.socialsecurity.gov/applyonline**.
- Click on the link that says "Apply for disability benefits". On the following screen, select the appropriate boxes and click "Apply for Benefits".
- Make sure that you save the Application Number you are given. You can use your Application Number to reenter your application or check the status of your application through the Social Security website from the address shown above.

See Next Page

- Follow the instructions to complete and submit both the application and the Disability Report.
- If you can only complete one of the forms before the appointment, please complete the Disability Report.

While applying through the internet is a good choice for many, you may choose not to do so and prefer to speak with a Social Security representative.

- If you have already requested an appointment, we will contact you soon to arrange an in office or telephone interview.
- If you have indicated that you will re-contact us when you are ready to file, you may call us toll free by dialing 1-800-772-1213 (TTY 1-800-325-0778) from 7AM to 7PM Monday through Friday.

Social Security Administration



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HUMAN SERVICES
WAYNE COUNTY



MAURA CORRIGAN
DIRECTOR

July 1, 2014

Morris, Tijuana
Apt 2
14841 Joy Rd
Detroit, MI 48228

Bridges Case Number: 115086200

Dear Sir/Madam:

The Department of Human Services has prepared the enclosed Hearing Summary because you have requested a hearing. It explains the actions taken on your case and lists the policy items used in taking these actions.

Also enclosed are copies of the documents the Agency plans to present as evidence at your hearing. Please review these documents and bring them with you to the hearing. You may call if you have questions at 937-5220 .

Copies of this information have been sent to Administrative Hearings in Lansing and to your authorized hearings representative, if you have one. Administrative Hearings will notify you of the date, time, and location of the hearing by letter.

Sincerely,

E. Luther
Casework Supervisor
Wayne County D.H.S.

Copies to: Client's representative
Hearings Coordinator

District 35 Office, 27260 Plymouth Road, Redford, Michigan 48239

www.michigan.gov



HEARING SUMMARY
Michigan Department of Human Services
ADMINISTRATIVE HEARINGS

Case Name: Tijuana Morris
Case Number: 115086200
Date: 06/25/2014
DHS Office: WAYNE CO DHS REDFORD SERVICE CENTER
Specialist: T. Baker
Phone: (313) 937-5261
Fax: (313) 937-4326
Specialist ID: baker18

CLIENT REQUESTED HEARING REGARDING ASSISTANCE OR SERVICE ACTIONS:

1. Date DHS Received Hearing Request 06/27/2014		2. Date Client Notified of Department Action 05/12/2014		3. Action Effective Date 05/12/2014	
4. Date of Administrative Review 06/25/2014		5. Actions Prompting Hearing Request <input type="checkbox"/> Termination <input checked="" type="checkbox"/> Denied Application <input type="checkbox"/> CPS Expunction Denial <input type="checkbox"/> Reduction <input type="checkbox"/> Other:		6. Hearing Request Recorded in Bridges <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
7. Benefits Restored? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. Date Claimant Offered Case Conference 06/25/2014 <input checked="" type="checkbox"/> Accepted <input type="checkbox"/> Rejected		9. Date DHS-1560 Sent 06/20/2014	
10. Amount of Monthly Benefits \$ 0.00		11. Benefits Before Negative Action \$ 0.00		12. Benefits After Negative Action \$ 0.00	
13. Employment Related Activities? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
14. Programs Impacted By the Department Action: <input type="checkbox"/> FIP <input type="checkbox"/> FAP <input type="checkbox"/> MA Eligibility <input type="checkbox"/> SDA Eligibility <input type="checkbox"/> HMP <input type="checkbox"/> CDC <input type="checkbox"/> ADOPTION SUBSIDY <input checked="" type="checkbox"/> SER <input type="checkbox"/> PATH <input type="checkbox"/> MA Disability <input type="checkbox"/> SDA Disability <input type="checkbox"/> Other <input type="checkbox"/> CPS <input type="checkbox"/> EXPEDITED					
15. Case Address Tijuana Lee Morris Apt 2 14841 Joy Rd Detroit MI 48228 (313) 208-8323					

DEPARTMENT REQUESTED HEARING:

<input type="checkbox"/> Intentional Program Violation (IPV)	<input type="checkbox"/> Debt Collection
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Explanation of action taken and facts and fact sources used in taking action:

Client requested a hearing due to denial for the State Emergency Relief Program. Self-attested monthly income of \$3018.00 reported by client on DHS-1004 signed on 05/09/2014(Exhibit 1 DHS-1004 PAGES 4-6) is higher than the maximum allowed for state emergency relief. Income verified via pension statement with a check date of 05/01/2014(Exhibit 2 PAGE 7).

Law and regulation(s) or manual item(s) used in taking action:

ERM 103

Prepared by

T.Baker

Date

06/25/2014

Attach a copy of papers to be used at the hearing, INCLUDING MEDICAL INFORMATION where at issue. Submit original Hearing Summary WITHIN 15 DAYS of receipt of the hearing request to: DHS, Administrative Hearings, P.O. Box 30639, Lansing, MI 48909-8139. DISTRIBUTE one copy of this Summary, with all attachments, to claimant/attorney and retain one copy.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.



REQUEST FOR HEARING
State of Michigan
Family Independence Agency

INSTRUCTIONS: Complete items 10 through 16 below. Please type or print. DELIVER OR MAIL completed form to your local FIA office, Attn: Hearing Coordinator. A date-stamped copy will be returned to you by the local office.

1. Case Name (Last) MOKKIS		(First) TISHOMI	
2. Program(s) in Dispute SED		3. Case Number 115086200	
4. County	5. District	6. Unit	7. Worker T. Baker / Luther
8. Date Received			
9. Telephone Number			

Esta forma se usa para solicitar una audiencia con un juez de ley administrativa cuando usted no está de acuerdo con una decisión que se hizo tocante a su caso. Si usted no entiende esta forma o necesita ayuda para completarla, comuníquese con su oficina local de la Agencia para la Independencia de la Familia al número de teléfono indicado en esta forma.

هذه الاستمارة تستعمل لطلب المرافعة مع حاكم قضائي إداري عندما لاتوافق على قرار يتخذ بخصوص قضيتك. إذا لم تستطع فهم هذه الاستمارة أو احتجت الى مساعدة لملء الاستمارة اتصل بالمكتب المحلي لوكالة الخدمات العائلية على الرقم المبين في الاستمارة.

AUTHORITY: MCL 400.8, MSA 16.409
RESPONSE: Voluntary.
PENALTY: None

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

10. I request a hearing before an Administrative Law Judge regarding the decision of the _____
County Family Independence Agency. Following are my reasons for requesting a hearing:

Name of County

I'm Requesting an IN PERSON HEARING CONCERNING my Request for DTE ASSISTANCE I have been waiting for a month, I talked to persons at THE FRONT DESK of DHS TWO TIMES. I WAS TOLD THAT my CASE IS PENDING, I HAVE NO DHS ASSISTANCE w/ CASE WORKER

JUN 20 2014

Due 6-27-14

By my signature below, I acknowledge that I understand that if a proposed action is not taken because I have requested a hearing and the Agency's proposed action is upheld, or if I later agree that the Agency's proposed action was correct and withdraw my hearing request, or if I do not appear for the hearing, then I will be required to repay any assistance which I would not have received if I had not asked for a hearing.

☐ DO ☐ DO NOT want to continue receiving the amount of food stamps I now receive until after my hearing.

11. Signature of Person Requesting Hearing (AH must receive an original signature. If this form is signed by an authorized hearing representative, documentation of authorization must be attached.)

12. Telephone Number

13. Date

14. Street Address or Route Number

15. City, State and Zip Code

16. Are special arrangements required for you to participate in a hearing?

☐ Yes ☒ No Explain:

THIS SECTION TO BE COMPLETED ONLY IF SOMEONE HAS AGREED TO REPRESENT YOU AT THE HEARING.

17. Name of Authorized Hearing Representative

18. Telephone Number

19. Title

20. Street Address or Route Number

21. City, State, and Zip Code

WAYNE CO DHS
REDFORD SERVICE CENTER
27260 PLYMOUTH
REDFORD MI 48239

Case Name: MORRIS, TIJUANA
Case Number: 115086200
Date: 06/20/14
DHS Office: WAYNE CO DHS
Specialist / ID: T. Baker /
Phone: 313 937-5261
Fax: 313 937-4326
Individual ID: bakert8

STATE OF MICHIGAN
Department of Human Services

If you do not understand this, call a DHS office in your area.
DHS employees are prohibited by law from providing legal advice.
Si usted no entiende esto, llame a una oficina de DHS en su área.
La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.
يحظر القانون على موظفي DHS إعطاء النصيحة القانونية.

Tijuana Morris
APT 2
14841 JOY RD
DETROIT, MI 48228

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

"USDA is an equal opportunity provider and employer."

PRE-HEARING CONFERENCE

We have received your administrative hearing request for the SER program(s). The first step in this process is a pre-hearing conference with the caseworker and the DHS supervisor. At this conference you will have an opportunity to further explain the reason(s) for your hearing request and the Department will explain the action(s) taken on the program(s). You may also want to present additional information you feel is important to the hearing issue. This conference does not in any way affect your right to a hearing but is an attempt to quickly resolve the issue, if at all possible.

The conference is scheduled for 07/01/14 at 9:00AM at our office Redford - DHS

If this date and time is not convenient for you, please call to discuss or reschedule the appointment.

Sincerely,

Ms. Luther
Supervisor
Title

Telephone Number 313-937-5220

WAYNE CO DHS REDFORD SERVICE CENTER
27260 PLYMOUTH RD
REDFORD MI 48239

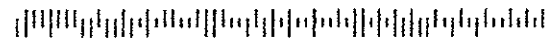
Case Name: Tijuana Morris
Case Number: 115086200
Date: 05/02/2014
DHS Office: WAYNE CO DHS REDFORD SERVICE CENTER
Specialist / ID: T. Baker / bakert8
Phone: (313) 937-5261
Fax: (313) 937-4326
Individual ID: 14701817

STATE OF MICHIGAN
Department of Human Services

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DHS employees are prohibited by law from providing legal advice.
Si usted no entiende esto, llame a una oficina de DHS en su área.
La ley prohíbe a los empleados de DHS proporcionar asesoría legal.
إذا واجهت صعوبة في فهم هذا الطلب، فاتصل بمكتب DHS الموجود في منطقتك.
يحظر القانون على موظفي DHS إعطاء النصيحة القانونية.

TIJUANA LEE MORRIS
APT 2
14841 JOY RD
DETROIT MI 48228

WAYNE CO DHS REDFORD SERVICE CENTER
27260 PLYMOUTH RD
REDFORD MI 48239-9984



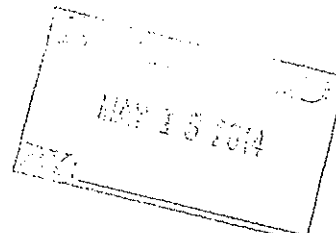
HEALTH CARE COVERAGE SUPPLEMENTAL QUESTIONNAIRE

Due Date: 05/12/2014

Why Are You Getting This Notice? We need some additional information to find the most beneficial health care coverage for you or a member of your family.

- What Steps Should You Take?
 - You must complete, sign, and date this form, and return it by the due date.
 - Include a copy of all proofs that are listed in each section of this form.
 - Original documents which are received as proof may not be returned.
 - The completed form and a copy of all proofs must be returned by the due date listed above. Please make sure your name is on all proofs.
- What Happens If You Do Not Return the Completed Form and Required Proofs by the Due Date?
 - For new applicants: If you do NOT return this form and all of the required proofs by the due date, your request for health care coverage may be denied.
 - For existing Medicaid recipients: Your benefits will continue at the current level.
 - If you receive Medicare: A determination for the Medicare Savings Program may not be made.
- If you do not understand this form and need help completing it, contact the specialist listed above before the due date.
- Complete this form to allow us to determine the most beneficial health care coverage. If you need additional space to provide your answers, use Client Comments Section on page 3.
- To apply for additional programs, please visit www.michigan.gov/mibridges, or contact the DHS office in your area.
- If you have questions or problems getting the proofs before the due date, please contact the specialist listed above. If you ask for help getting your proofs, your specialist may be able to assist you.

over



Case Name Tijuana Morris	Case Number 115086200	Specialist T. Baker / baker8
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MEMBERS OF HOUSEHOLD – Below are the names of people we show living in your household. Cross out incorrect information and write the correct information in the space provided. Add names and information about people living with you who do not appear on this form. Complete all columns. If more space is needed, report additional information in Client Comment Section on page 3.

Name	Date of Birth	Relationship to you	Social Security Number	Gender (please circle)	U.S. Citizen? Yes/No	Pregnant now/in last 3 months? Yes/No	If Pregnant, Expected Due Date
Tijuana Lee Morris	03/30/1955	SELF		M <input checked="" type="radio"/> F	YES	NO	
				M F			
				M F			
				M F			
				M F			
				M F			

FACILITY – List any person in your household who lives in a facility.

Patient's Name	Name of Facility	Date of Facility Admission	Address Where You Lived Before You Entered the Facility

	Yes	No	Amount	How Often Paid
Do you and/or your spouse have a rent, mortgage or other shelter expense?	<input type="checkbox"/>	<input type="checkbox"/>		

DISABILITY – List any person in your home who is blind or has a disability.

Name	Medical Condition	Is this person able to work?	
SELF	PLEASE SEE ATTACHED DOCUMENT FOR NECK BACK RIGHT ARM AREAS FINGERS	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<input type="checkbox"/> Yes	<input type="checkbox"/> No

INCOME SOURCE - Report all sources of earned and unearned income. Send proof of all income your household received. Send proof of the last 30 days for employment, unemployment, social security benefits, pension, etc. Send proof of the last 90 days for child support and self-employment income/expenses records. Examples of proof include check stubs, a statement from source of income.

Recipient's Name	Income Source	Gross Amount (Before deductions)	*Number of Expected Hours of Work Per Pay Period	Frequency (Weekly, Bi-weekly, Monthly)	Start/End/Change Date
SELF	DISABILITY PENSION DETROIT POLICE DEPARTMENT	3018.00			

Case Name Tijuana Morris	Case Number 115086200	Specialist T. Baker / baker8
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EXPENSES YOU OR YOUR SPOUSE ARE RESPONSIBLE TO PAY - Send proof of all expenses with your name on it.

Type of expense to report	Name of Person Who Incurred the Expense	Type of Expense	Amount of Expense	Amount You are Responsible to Pay
<ul style="list-style-type: none"> Guardian Conservator Child Support - court-ordered Care for Adult with Disabilities Employment-related Dependent Care Expenses Medical 	SELF	MEDICAL	3,090.00	3090.00
	"	MEDICATIONS	3,000.00 Plus	3000.00 Plus

ASSETS -Report all assets. This may include: bank accounts, land, cars, other vehicles, boats, life insurance, investments, lawsuit settlements, trusts, annuities or any other property (including in trust). Report if anyone bought, sold, transferred, gave away or received any asset in the last 60 months. Provide proof with your name on it. If more space is needed, use the Client Comment Section below.

	Name of Owner	Financial Institution	Account Number	Balance	New/Change Date
Savings	TIJANA MORRIS	FIRST INDEPENDENCE		200.00	
Checking	072001079-02007023730				
CREDIT CARD - CAPITAL ONE			5440-4560-2102-5102	500.00	
Other	"		5155-9700-3222-4505	600.00	
CAR INSURANCE SELF	STATE FARM INS		284 4450-802-22C	356.00 PER MONTH	

PENALTY WARNING

"Under penalties of perjury, I swear or affirm that this application has been examined by or read to me, and, to the best of my knowledge, the facts are true and complete. If I am a third party applying on behalf of another person, I swear or affirm that this application has been examined by or read to the applicant, and, to the best of his/her knowledge, the facts are true and complete."

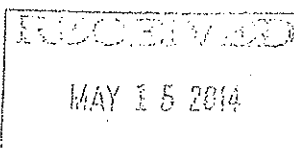
I certify, under penalty of perjury, that all the information I have written on this form or told to my DHS specialist or my representative is true. I understand I can be prosecuted for perjury if I have intentionally given false or misleading information, misrepresented, hidden or withheld facts which caused me to receive assistance I should not have received or more assistance than I should have received. I can be prosecuted for fraud and/or required to repay the amount wrongfully received. I understand I may be asked to show proof of any information I have given.

Signature of Client or Authorized Representative <i>Tijuana Morris</i>	Date 5-9-14	Telephone Number 313-208-8323	Signature of Department Witness	Date
Telephone Number where you can be reached or where we can leave a message				

CLIENT COMMENTS (may also report additional information here)

LEASE CAR 2013 HYUNDAI Plate #4J5L60 \$280.00 PER MONTH
STORAGE \$65.00 COURT ORDER JUDGEMENT \$106,947.35 & 10,486.35
RENT \$50.00 PER MONTH To Pay People To Help with my PERSONAL
NEEDS WHEN I CAN AFFORD IT AND HOME CARE. UTILITIES 150.00
PER MONTH. I HAVE NO HEALTH INSURANCE I AM A RETIRED DETROIT
POLICE OFFICER PLEASE SEE ATTACHMENTS DRD GROUPS THERE INS. COVER

Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.



COVERAGE

PENSION STATEMENT

Police and Fire Retirement System
of the City of Detroit
2 Woodward Ave Ste 908
Detroit, MI 48226-3455

Page 001 of 001
Period Beginning: 04/01/2014
Period Ending: 04/30/2014
Check Date: 05/01/2014
Check Number: 7000158479
Batch Number: 000000000537

Retirement Code B-41-0-7

Tax Code No Withholding
Pension No 230371
Social Security No XXX-XX-2534

MORRIS, TIJUANA L
PO BOX 23712
DETROIT MI 48223-0712

EARNINGS	RATE	ADJUSTMENT	CURRENT	YTD	DEDUCTIONS	DEDUCTION CODE	CURRENT	YTD
Pension	3018.93	0.00	3018.93	15094.65	Federal Income Tax		0.00	0.00
Annuity	0.00	0.00	0.00	0.00	Michigan Income Tax		0.00	0.00
					Death Benefit	00040210	0.09	0.45
					DPOA Group Ins	00040620	45.33	197.99
					Police Benefit & Pro	00040315	18.55	92.75
					Retired Assoc Dues	00080100	3.00	15.00

Gross Pay 3018.93 15094.65 Total Deductions 66.97 647.89
Net Pay \$2,951.96

IMPORTANT NOTES☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, and ZIP code POLICE AND FIRE RETIREMENT SYSTEM OF THE CITY OF DETROIT 2 WOODWARD AVE RM 908 DETROIT, MI 48226-3455		1 Gross Distribution \$35,781.75		OMB No. 1545-0119 2013		Distributions from Pensions, Annuities, Retirement or Profit- Sharing Plans, IRAs, Insurance Contracts, etc.
		2a Taxable Amount \$0.00		Form 1099R		
PAYER'S Federal Identification number 38-2465279	RECIPIENT'S Identification number [REDACTED]	2b Taxable amount not determined <input type="checkbox"/>		Total Distribution <input type="checkbox"/>		Copy C For Recipient's Records
REDUCED DUTY DISABILITY * RECIPIENT'S Name and Address MORRIS TIJUANA L PO BOX 23712 DETROIT, MI 48223-0712		3 Capital gain (Included in box 2a)		4 Federal income tax withheld \$0.00		
		5 Employee Contributions / Designated Roth Contributions or insurance premiums		6 Net unrealized appreciation in employer's securities		
		7 Distribution Code(s) 3	IRA/SEP/SIMPLE	8 Other		
		9a Your percentage of total distribution		9b Total employee contributions		This information is being furnished to the Internal Revenue Service.
		12 State tax withheld		13 State/Payer's state no.		
		15 Local tax withheld		16 Name of locality		
10 Amount allocated to each year		11 Date of death or annuity		17 Local distribution		

REQUEST FOR A HEARING

Case Name: Tijana Morris

Case Number: 115086200

Specialist Name: T. Baker

Notice Date: 05/12/2014

DHS Office: Wayne Co DHS Redford Service Center

Fax:

Right to an Administrative Hearing

If you want to continue getting your current benefits while you appeal this action, DHS must receive your hearing request within 10 days of the mailing date of this notice, on or before **05/23/2014**.

If you think the action being taken is wrong, and want to appeal, DHS must receive your hearing request within 90 days of the mailing date of this notice, on or before

If DHS receives your hearing request after 10 days of the mailing date of this notice, but within 90 days of the mailing date of this notice, you will still be granted a hearing, but your assistance will be discontinued.

If you win at the hearing, your benefits will be reinstated. If you do not win, your benefits will not be reinstated. If DHS does not receive your hearing request within 90 days of the mailing date, then you will not be granted a hearing.

If the Department stops this action because of your hearing request, then you may be **required to repay** any assistance that you receive after this action was stopped if (1) the Department's proposed action is upheld in the hearing decision, or (2) your hearing request is withdrawn, or (3) you or your authorized representative do not attend this hearing.

For Food Assistance, you may request a hearing in writing or by telephone. Hearing requests for all other programs must be made in writing by you or your authorized representative.

If you are currently receiving assistance:

Your hearing request must be received by the DHS on or before **05/23/2014**, to continue your assistance at the former level or to have your current assistance continued or reinstated. Someone else may help or represent you with the hearing (lawyer, friend, social worker, relative, etc., - see below).

You may choose anyone to represent you. If that person is not a lawyer or is not appointed by a court, you must give us your signed authorization. If the person is court appointed to help you, they must show us the order of appointment. Otherwise if you do not provide proof of authorization, the Michigan Administrative Hearings System will deny the request for an administrative hearing made by the representative.

How to request an Administrative Hearing:

- To request a hearing, fill out and sign the back of this page.
- You may write your reasons on the back of this page. **Keep a copy for yourself.** Mail, fax or bring the form, signed and dated, to the hearings coordinator at the local Department of Human Services office.
- At the hearing, you can explain why you think this action is wrong, and give evidence.

If you want to know more about how a fair hearing works, contact your local DHS office. To find out if free legal help is available in your area, visit <http://www.michiganlegalaid.org/> to learn about legal aid organizations in your area.

For Genesee County:

You may be scheduled for a local evidentiary hearing, with a right of appeal to the Michigan Administrative Hearing system. Once scheduled, you will receive written notice of when and where to appear for your local evidentiary hearing.

If you want to know more about the hearings pilot:

- The pilot policy may be found on the DHS Public Web site at www.michigan.gov/dhs
- You may contact your caseworker, or visit or call your local DHS office and ask for more information.



Case Name Tijuana Morris	Case Number 115086200	Specialist T. Baker	Date 05/12/2014
------------------------------------	---------------------------------	-------------------------------	---------------------------

Complete this section only if you want to request a hearing:

Please check only the box(es) of the benefit program(s) for which you are requesting a hearing and the action(s) taken that you are challenging.

- | | | | |
|---|---------------------------------|---------------------------------|---|
| <input type="checkbox"/> Cash | <input type="checkbox"/> Denied | <input type="checkbox"/> Closed | <input type="checkbox"/> Amount of benefits |
| <input type="checkbox"/> Child Development and Care | <input type="checkbox"/> Denied | <input type="checkbox"/> Closed | <input type="checkbox"/> Amount of benefits |
| <input type="checkbox"/> Food Assistance | <input type="checkbox"/> Denied | <input type="checkbox"/> Closed | <input type="checkbox"/> Amount of benefits |
| <input type="checkbox"/> State Emergency Relief | <input type="checkbox"/> Denied | <input type="checkbox"/> Closed | <input type="checkbox"/> Amount of benefits |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Denied | <input type="checkbox"/> Closed | <input type="checkbox"/> Amount of benefits |

Please check the appropriate box(es) if your request involves an issue listed below:

- ☐ Child Support ☐ Employment and Training

I request a hearing because I disagree with the action(s) of the Department of Human Services. I think the decision is incorrect because:

Do you have physical or other conditions requiring special arrangements for you to attend or participate in a hearing? Yes No

Check yes if you want to continue receiving the amount of Food Assistance that you now receive until your hearing is decided. Yes No

Sign to request a Hearing	Telephone	Date
----------------------------------	-----------	------

If you have someone helping you at the hearing, complete the section below.

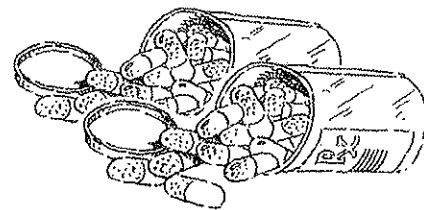
Name of Representative: _____ Title: _____ Phone Number: _____

Signature of Representative: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Si usted no esta de acuerdo con una acción descrita en este aviso o piensa que es incorrecto, usted puede solicitar una audiencia 90 días después de la fecha de este aviso. Para Asistencia de Alimentos, usted puede solicitar una audiencia por escrito o por teléfono. La solicitud de audiencia de todos otros programas debe, ser hecha por escrito y firmada por usted a una persona autorizada. Para solicitar una audiencia, firme y fecha en las líneas arriba. Envíe o trae esta pagina firmada y fechada a la oficina de Department of Human Services en su area. Por favor póngase en contacto con su especialista si usted tiene preguntas sobre este aviso o su derecho a una audiencia.

**DO YOU OR SOMEONE YOU KNOW
NEED HELP WITH PRESCRIPTION
DRUGS?**



**WORLD MEDICAL RELIEF'S
AFFORDABLE PRESCRIPTIONS PROGRAM
MAY BE THE ANSWER!**

Safe:	State-licensed pharmacy
Affordable:	\$8.30 per RX
Convenient:	In most cases, your medicine can be mailed directly to your home.

You may qualify if you:

- Are 18 years of age or older
- Earn \$21,780 or less per year if you are single; \$29,420 for a couple.
(Add \$300 for each additional dependent).
- Do not have prescription drug coverage, even though you may have
health insurance.
- Are not currently enrolled in Medicaid

**You may still qualify if you have a discount prescription card or are a senior on
Medicare Part D. Documentation of income is required.**

PLEASE CALL OR STOP IN FOR AN APPLICATION.

WORLD MEDICAL RELIEF, INC.

11745 Rosa Parks Blvd., Detroit, MI 48206 313-866-5333, fax: 313-866-5588,
email: info@worldmedicalrelief.org, website www.worldmedicalrelief.org



*Other services available through World Medical Relief include durable medical equipment such
as a hospital bed, wheelchair, shower chair, walker, cane, commode, etc. We also carry basic
medical, diabetic, and colostomy supplies, liquid nutrition, and incontinent products.*

EXHIBIT

7) Federal Monitor complaint

Fight for Your Rights Investigations Inc

220 Bagley St. 809
Detroit Michigan 48226
313-208-8323
msi3211@yahoo.com



December 01, 2012

US Eastern District Federal Court
US Federal Honorable
Judge Julian Cook
231 W Lafayette Room 718
Detroit Mi 48226
Ph# 313-234-5100

RE: Resolution of Complaint Sec. 7-1109, concerning the complaint filed on May 28, 2009, (complaint # 44337,BPC09-629), at the Commissioner Board meeting, concerning Traffic Officer Fitzgerald Harris badge #1440 S/8 a pedestrian/vehicle accident report in the parking lot of a CVS Store (13580 Grand River).

Judge Cook,

I sent a complaint with the Federal Monitor, Robert Warshaw via Email:rohtopcop@aol.com on October 11, 2012. I have not received a response concerning the above issue. I talked to your Clerk Kay. She requested that I mail this complaint to your office and that the complaint would be forward to the Federal Monitor.

I would like to thank you for your time and consideration. If you need more information please call me at 313-208-8323. I have enclosed the complaint that I sent to the Monitor and an Annual Report of the case work that I have done in the past.

Sincerely,

Tijuana Morris
Investigator

JOYFIELD STATION
DETROIT, Michigan
482269999
2524950226-0099
12/04/2012 (313)272-6819 05:08:20 PM

===== Sales Receipt =====
Product Sale Unit Price
Description Qty Price Price

DETROIT MI 48226 \$2.70
Zone-1 First-Class
Large Env
9.80 oz.
Expected Delivery: Thu 12/06/12
Certified \$2.70
Label #: 700914100001654249501
Issue PV: \$5.46

Total: \$5.46

Paid by:
Debit Card \$5.46
Account #: YXXXXXXYYXX(25)
Approval #: 491065
Transaction #: 584
25303040210
Receipt #: 000740

Order status at usps.com/stop or
call 1-800-Stamp24. Go to
usps.com/etkship to print
shipping labels with postage. For
other information call
1-800-ASK-USPS.

Get your best when and where you
want it with a secure Post Office
Box. Sign up for a box online at
usps.com/poboxes.

Bill #: 100020146803
Clerk: 07

All sales final on stamps and postage.
Refunds for guaranteed services only.
Thank you for your business.

HELP US SERVE YOU BETTER

Go to:
<http://postalexperience.com/Post>

TELL US ABOUT YOUR
POSTAL EXPERIENCE

YOUR OPINION COUNTS

U.S. Postal Service
CERTIFIED MAIL - RECEIPT
(Domestic Mail Only. No Insurance Coverage Provided)

For Business & Government use only. Send to a retail carrier.

NO POSTAL USE

Postage	\$ 43.70	0000
Certified Fee	\$2.70	07
Return Receipt Fee (Reimbursement Required)	\$0.00	
Registered Delivery Fee (Reimbursement Required)	\$0.00	
Total Postage & Fees	\$ 46.40	12/04/2012

Signature of Addressee: *John A. Cook*
or PO Box No. 331W LaFayette St Rm 718
DETROIT MI 48226

7009 1410 0001 6542 4950

EXHIBIT

8) Appeal Court information and Court Transcript
Judge's ruling (upon request if needed)

Court of Appeals, State of Michigan

ORDER

Tijuana Morris v State Farm Mutual Automobile Insurance Company

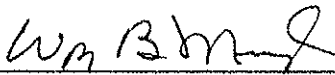
Docket No. 321378

LC No. 10-005725-NF

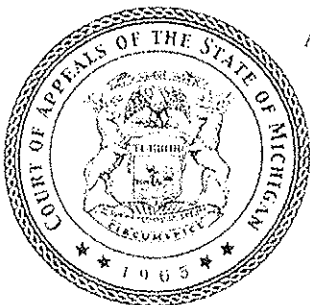
William B. Murphy, Chief Judge, acting under MCR 7.203(F)(1) and MCR 7.211(E)(2), orders:

The claim of appeal is DISMISSED for lack of jurisdiction because it was not filed within 21 days after entry of the March 7, 2014, order deciding appellant's motion for a new trial. MCR 7.204(A)(1)(b). At this time, appellant may seek to appeal only by filing a delayed application for leave to appeal under MCR 7.205(G).

The motion to waive fees is GRANTED for this appeal only.



William B. Murphy



A true copy entered and certified by Jerome W. Zimmer Jr., Chief Clerk, on

MAY 09 2014

Date



Chief Clerk

EXHIBIT

9) Pension Annuity statements



REC'D JAN 11 2010

POLICE AND FIRE RETIREMENT SYSTEM
CITY OF DETROIT



WITHDRAWAL/DISTRIBUTION FROM DEFINED CONTRIBUTION PLAN
(ANNUITY SAVINGS FUND)

DATE OF APPLICATION 1-11-2010
EMPLOYEE NAME TIJUANA MORRIS SOCIAL SECURITY # [REDACTED]
DATE OF BIRTH 03-30-55 TELEPHONE 313 208-8323

TO: BOARD OF TRUSTEES OF THE RETIREMENT SYSTEM

I attained or will attain eligibility for withdrawal of my Defined Contribution Plan (Annuity) amounts due to (Choose one)

- ☐ Service Retirement ☐ 20/25 Year Withdrawal Provisions
☐ Separation from Service ☐ Conversion from Disability
☐ Laid-off ☐ EDRO (Eligible Domestic Relations Order)
☐ Death of employee (Date _____) ☒ Quarterly Interest Withdrawal (Retired Only)

If Death or EDRO, please complete:

RECIPIENT/BENEFICIARY NAME _____ SOCIAL SECURITY # _____
DATE OF BIRTH _____ TELEPHONE (_____) _____

Pursuant to these provisions, I hereby request a withdrawal from my Defined Contribution Plan account as follows:

☐ Total withdrawal ☒ Partial withdrawal of \$ 55,000.00
(Initial) LM (Initial)
If partial withdrawal, write out dollar amount FIFTY FIVE THOUSAND
☐ Contributions prior to 8-14-1982 only.
(Initial)

to be distributed as follows:

If requesting more than pre-1982 contributions you must select EITHER 1, 2 or 2 and 3:

1. LM I request that full payment be made to me. I acknowledge that twenty (20%) percent of the
(Initial) taxable portion will be withheld in accordance with applicable Internal Revenue Code requirements and regulations.

2. I request a direct rollover of the otherwise taxable portion as follows: CHOOSE A or B

<p>A _____ All of the otherwise taxable portion (in (Initial) which case no withholding will apply to me)</p>	OR	<p>B _____ A portion totaling \$ _____ (Initial) of the otherwise taxable portion</p>
---	----	---

of my Defined Contribution Plan distribution be forwarded to:

Agency and Account No.: _____

Address: _____

City, State & Zip Code: _____

as a direct rollover/direct transfer and the balance paid to me. Any taxable portion not rolled over/transferred will be subject to the required twenty (20%) percent withholding. Representatives of the above named company have assured me that the direct rollover amount will be deposited in either a 401(a) of the Internal Revenue Code Plan, including a 401(k) plan, profit sharing plan, defined benefit plan, stock bonus plan, and money purchase plan; a section 403(a) annuity plan; a section 403(b) tax-sheltered annuity or an eligible section 457(b) plan maintained by a governmental employer (governmental 457 plan).

Annuity Refund Worksheet

Distribution Summary

21-JAN-10

SSN XXXXXXXXXX
 Participant Name TIJUANA MORRIS

Total Partial

Pretax Contributions		Interest		Posttax Contributions	
Prior Year	_____	Prior Year	_____	Pre-1982	_____
Current Year	_____	Current Year	_____	Prior Year	_____
	_____		_____	Current Year	_____
Total Pretax	_____	Total Interest	_____	Total Posttax	_____

Total Taxable 55,000.00
 Rollover amount _____
 Withholding 11,000.00

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL DISTRIBUTION 55,000.00

For EDROs and Death Beneficiaries

Participant or First Beneficiary

Name _____
 SSN (if different from above) _____

Total Taxable _____
 Rollover amount _____
 Withholding _____

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL _____

_____ Minor EDRO

Alternate Payee or Second Beneficiary

Name _____
 SSN _____

Total Taxable _____
 Rollover amount _____
 Withholding _____

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL _____

_____ Minor EDRO

Third Beneficiary

Name _____
 SSN _____

Total Taxable _____
 Rollover amount _____
 Withholding _____

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL _____

_____ Minor EDRO



Annuity Refund Worksheet

Distribution Summary

10-JUN-10

SSN 381-521-521

Total Partial

Participant Name TIJUANA MORRIS

Pretax Contributions	Interest	Posttax Contributions
Prior Year _____	Prior Year _____	Pre-1982 _____
Current Year _____	Current Year _____	Prior Year _____
Total Pretax _____	Total Interest _____	Current Year _____
		Total Posttax _____

Total Taxable 12,000.00
Rollover amount _____
Withholding 2,400.00

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL DISTRIBUTION 12,000.00

For EDROs and Death Beneficiaries

Participant or First Beneficiary

Name _____

SSN (if different from above) _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

____ Minor EDRO

Alternate Payee or Second Beneficiary

Name _____

SSN _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

____ Minor EDRO

Third Beneficiary

Name _____

SSN _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

____ Minor EDRO



Annuity Refund Worksheet

Distribution Summary

09-SEPT-10

SSN XXXXXXXXXX

Total

Partial

Participant Name TIJUANA MORRIS

Pretax Contributions	Interest	Posttax Contributions
Prior Year _____	Prior Year _____	Pre-1982 _____
Current Year _____	Current Year _____	Prior Year _____
Total Pretax _____	Total Interest _____	Current Year _____
		Total Posttax _____

Total Taxable 2,200.00
 Rollover amount _____
 Withholding 440

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL DISTRIBUTION 2,200.00

For EDROs and Death Beneficiaries

Participant or First Beneficiary

Name _____

SSN (if different from above) _____

Total Taxable _____
 Rollover amount _____
 Withholding _____

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL _____

____ Minor EDRO

Alternate Payee or Second Beneficiary

Name _____

SSN _____

Total Taxable _____
 Rollover amount _____
 Withholding _____

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL _____

____ Minor EDRO

Third Beneficiary

Name _____

SSN _____

Total Taxable _____
 Rollover amount _____
 Withholding _____

Total Nontaxable _____
 Nontaxable Rollover _____
 TOTAL _____

____ Minor EDRO



Annuity Refund Worksheet

Distribution Summary

12/16/10

SSN

Participant Name

TIJUANA MORRIS

Total

Partial

Pretax Contributions	Interest	Posttax Contributions
Prior Year _____	Prior Year _____	Pre-1982 _____
Current Year _____	Current Year _____	Prior Year _____
Total Pretax _____	Total Interest _____	Current Year _____
		Total Posttax _____

Total Taxable 7,000.00
Rollover amount _____
Withholding 1,400.00

Total Nontaxable 0.00
Nontaxable Rollover _____
TOTAL DISTRIBUTION 7,000.00

For EDROs and Death Beneficiaries

Participant or First Beneficiary

Name _____

SSN (if different from above) _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

____ Minor EDRO

Alternate Payee or Second Beneficiary

Name _____

SSN _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

____ Minor EDRO

Third Beneficiary

Name _____

SSN _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

____ Minor EDRO



Annuity Refund Worksheet

Distribution Summary

7/19/11

SSN

Participant Name

Triguna Morris

Total

Partial

Pretax Contributions	Interest	Posttax Contributions
Prior Year _____	Prior Year _____	Pre-1982 _____
Current Year _____	Current Year _____	Prior Year _____
Total Pretax _____	Total Interest _____	Current Year _____
		Total Posttax _____

Total Taxable 1,192.83
Rollover amount _____
Withholding 238.57

Total Nontaxable 1,159.56
Nontaxable Rollover _____
TOTAL DISTRIBUTION 2,352.39

For EDROs and Death Beneficiaries

Participant or First Beneficiary

Name _____

SSN (if different from above) _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

Minor EDRO

Alternate Payee or Second Beneficiary

Name _____

SSN _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

Minor EDRO

Third Beneficiary

Name _____

SSN _____

Total Taxable _____
Rollover amount _____
Withholding _____

Total Nontaxable _____
Nontaxable Rollover _____
TOTAL _____

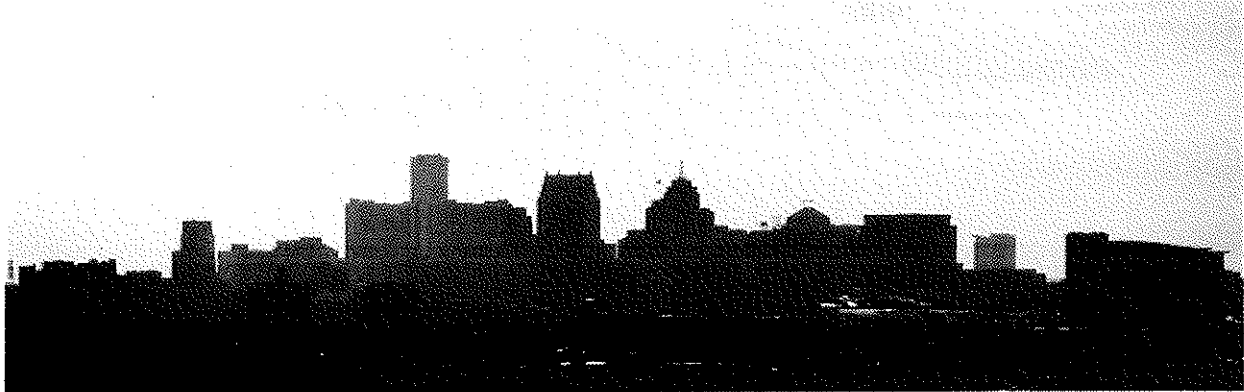
Minor EDRO



EXHIBIT

- 10) Jonathan Oosting | joosting@mlive.com
Follow on Twitter

How Michigan's revenue sharing 'raid' cost communities billions for local services



The Detroit skyline. (Jonathan Oosting | MLive.com)

[Print](#)



By [Jonathan Oosting | joosting@mlive.com](#)

[Follow on Twitter](#)

on March 30, 2014 at 7:04 AM, updated April 13, 2014 at 1:13 AM

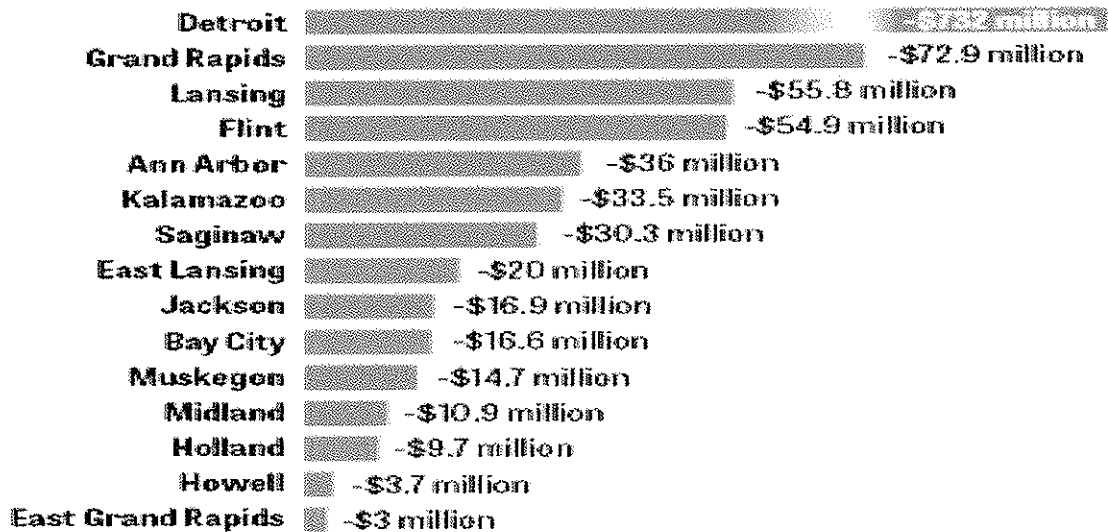
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[Reddit](#)

[Email](#)

REVENUE SHARING DIVERSION

Revenue sharing dollars diverted by the state from select Michigan cities since 2003.



Sources: Michigan Municipal League;
Michigan Department of Treasury

(Edward Rojas/MLive.com)

LANSING, MI -- Michigan is home to a number of struggling cities, making it easy to point the finger at local officials, declining property tax revenues or other economic factors that have effected the nation as a whole.

But many local leaders will also point to Lansing.

Over the past decade, lawmakers and governors from both political parties have used some \$6.2 billion in sales tax collections to fill state budget holes rather than fulfill a statutory revenue sharing promise to local communities, according to the Michigan Municipal League, which released a city-by-city analysis earlier this month.

The figures, which are based on data from the Michigan Department of Treasury and adjusted for inflation, are staggering. In many instances, the losses have resulted in steep cuts to government staffing and public services that residents rely on.

Detroit, which filed for bankruptcy protection last year, missed out on \$732 million between 2003 and 2013, per the report. Flint, under control of an emergency manager, could have had an extra \$54.9 million to work with. Cities like Pontiac and Lansing have lost more than \$40 million each.

The Municipal League says the annual budget "raid" has diverted money that should have been used to maintain city services. It argues that the Legislature has helped caused some of the very financial emergencies that have prompted state takeovers or other forms of intervention.